CLAIMS CLUES

JUNE 2005

AHCCCS would like to clarify reimbursement for emergency ground transportation services. Transportation services are currently reimbursed one of three ways.

1. For ground ambulance providers whose rates are published in the schedule of General Public Rates/Charges by the Arizona Department of Health Services (ADHS), the fee schedule amount for base, mileage, and wait time is 80% of the ambulance provider's ADHS published rate.
2. For ground ambulance providers whose rates are not published by ADHS, the fee schedule amount or covered billed charges.
3. For other ambulance ground services including, but not limited to, oxygen and supplies for which no fee schedule amount has been set, reimbursement is made at the "BR rate", which is 80% of the provider's billed charges.

Ahcccs Dental Providers

Effective **July 1, 2005,** Dental Codes **D9211** regional block anesthesia, **D9212** trigeminal division block anesthesia and **D9215** local anesthesia will no longer be a reimbursable dental benefit.

If you have any questions regarding this or other dental issues, please contact Dr. Robert Birdwell, AHCCCS Dental Director at 602-471-4198.

Medicare Modernization Act :

Due to the Medicare Modernization Act of 2003, effective January 1, 2006, full Medicaid eligible members who are also entitled to or enrolled in Medicare Part A or enrolled in Medicare Part B (dual eligibles) will no longer have their prescription drugs covered by AHCCCS (Medicaid). Arizona has over 90,000 dual eligible members that will be impacted by this change. Medicare Part D will provide their prescription drug coverage. AHCCCS will only continue to cover the following medically necessary drugs, which are excluded from Part D: benzodiazepines, barbiturates and over the counter drugs.

All dual eligible members must choose a Part D plan from which to receive their prescription drugs. Each Part D plan may have its own formulary, therefore, members will need to compare the plans available in their service area and choose the one that best fits their needs. As of yet, the Center for Medicare and Medicaid Services has not awarded the contracts for the prescription drug benefit. Some AHCCCS Health Plans and Program Contractors have applied to become Medicare Advantage-Prescription Drug Plans and will provide both the Medicaid and Medicare services to their enrolled members. This will allow for better coordination of care for their members.

People with Medicare who have limited income will receive assistance in the form of a subsidy with most of the cost sharing requirements of Part D. CMS will pay the cost-sharing subsidy to the prescription drug plan that the member enrolls with. CMS calls this the Limited Income Subsidy (LIS). All full Medicaid dual eligible members will automatically receive this assistance and do not have to apply for it. Dual eligible members will be responsible for copayments ranging from $1 - $5 depending on their income.

If members request information on Medicare Part D or the Limited Income Subsidy, they can be referred to: The Social Security Administration website at www.socialsecurity.gov or they can call 1-800-MEDICARE;

The Centers for Medicare and Medicaid Services website at www.cms.hhs.gov; or The state SHIP office at 1-800-432-4040.

Look for additional information in the near future in Claims Clues and in other publications leading up to the January 1, 2006 transition date.

Prior Authorization Hours Changed:

Please note the new hours to reach the AHCCCS Prior Authorizations department. When calling for a PA, please see listed phone time changes:

9:00am – 11:30am and 12:30pm – 4:00pm

Please note that you may fax your request for PA at anytime to 602-256-6591.

Selecting Electronic Payment Is Easy, Convenient

AHCCCS has made it easy for providers to begin receiving electronic Fee-For-Service reimbursement. The electronic payment option processes payments using the Automated Clearing House (ACH) rather than issuing checks to providers.

The ACH payment method enables providers to receive reimbursement more quickly.

The Arizona Clearing House Association (ACHA) processes electronic payments directly to the provider's bank account through Bank of America, which functions as the state-servicing bank.

BofA will make the electronic payment available to a provider's account one business day after the date AHCCCS transmits the ACH payment file to BofA.

The ACH process offers several benefits to providers, including:

- Immediate availability of funds
- Fully traceable payments
- Elimination of mail and deposit delays
- Elimination of lost, stolen or misplaced checks

To begin receiving ACH payments, a provider must complete section 2 and 3 of the ACH Vendor Authorization form. The form is available on the AHCCCS web site at WWW.ahcccs.state.az.us. Click on links for Plans and Providers. On the quick links for Health Plans & Providers page, click on forms, and then scroll down to the ACH Vendors Authorization Form.

OUTPATIENT HOSPITAL FEE SCHEDULE METHODOLOGY TO CHANGE FOR DATES OF SERVICE 7/1/2005 AND AFTER

AHCCCS has developed and will implement, EFFECTIVE 7/1/2005, an outpatient hospital fee schedule with features similar to Medicare:

- Group procedures into Ambulatory Payment Classifications (APCs) for rate setting purposes (using grouping methodology from Medicare 2005 rule).

- Grouping items that bundle with surgery and ED claims for pricing purposes (using list of revenue codes from Medicare 2005 rule).

AHCCCS will reimburse in-state, non-IHS hospitals for outpatient services billed on a UB-92 claim for using the AHCCCS Outpatient Hospital Fee Schedule.

- The Outpatient Hospital Fee Schedule will provide rates at the procedure code level, and covered procedures that do not have a specific rate on the fee schedule will be paid at the default cost-to-ratio.

- Payment for surgery procedures and for Emergency Department (ED) services will be bundled similar to Medicare.

- Multiple surgeries will pay the higher rate surgery at 100% of the fee schedule and secondary surgeries at 50% of the fee schedule (exceptions will be noted for those procedures that are intended to be paid at 100%

- Late charge bills will no longer be accepted.

- When billing adjustments (including late charges), hospitals must rebill the entire claim.

- Incorrectly submitted claims will not deny/disallow at the line level. If one line of the claim is billed incorrectly, the entire claim will be denied.

- Out-of-State outpatient hospital claims will be reimbursed using the AHCCCS Outpatient Hospital Fee Schedule or a negotiated rate.

- AHCCCS will require that outpatient services be billed with an appropriate CPT or HCPCS code that further defines the services described by the revenue code listed on the UB-92 claim form.

- Labor and Observation must be billed with Revenue Code 721 as well as the appropriate CPT/HCPCS codes.

A complete description of the billing/reporting requirements for the AHCCCS Outpatient Hospital Fee Schedule will be provided in the AHCCCS Fee-For-Service Provider Manual. Additional information regarding the Outpatient Fee Schedule will be provided in future Claims Clues, and once finalized, it will be posted to the AHCCCS website.

NEWSFLASH: Please note that Chapters 6 & 11 of the AHCCCS FFS Provider Manual have been updated with various Outpatient information and are now posted on the Web for your convenience.

SUMMER